



770 West Ridge Rd
Wytheville, VA 24382

276-223-3200

mountrogers.org

Individual's Name:

Individual's DOB

Authorization to Disclose

Full name of person(s) authorizing disclosure of Protected Health formation*

authorize(s) Mount Rogers Community Services *

- To disclose to
- Exchange with
- Obtain from

Please check all that apply:

- My Treating Healthcare Providers
- Health Plans
- Third-Party Payers
- People helping to operate these programs

Exceptions or Restrictions (please list by name or Agency):

Disclosure may include [check all that apply]

- AIDS or HIV related information
- Other Infectious Diseases (such as TB, Hepatitis, etc.)



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Purpose of disclosure or treatment, payment and healthcare operations.

As the person signing this Authorization to Disclose Protected Health Information, I understand that I am giving permission for Mount Rogers Community Services to release or obtain and use confidential health information. I understand that treatment, payment, enrollment or eligibility for benefits is not affected by signing this form for mental health, physical health, Substance Use and ID/DD protected healthcare information. I understand that I may refuse to sign this Authorization. I also understand that the information disclosed may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and may no longer be protected by state law and/or 42 CFR, Part 2. I also understand that if HIPAA covered entities or business associates receive these records for treatment, payment, and healthcare operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative legal proceedings against me. This Authorization will be included in my service record, and a copy will be provided to me.

I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken in reliance on it. I will notify Mount Rogers CS in writing of my desire to revoke this Authorization; my revocation is not effective until delivered in writing to the person in possession of my records. I understand this Authorization extends to information placed in my record after the date I signed this Authorization, unless otherwise requested

Unless otherwise revoked, this Authorization will expire on Discharge Date.

**** Authorization must be signed by the individual or authorized representative.**

Basis of Representative's authority to sign Authorization on behalf of the individual (e.g. parent, guardian, etc.)

This Authorization requires the individuals or authorized representative's signature.

A copy of this Authorization must be given to the individual or authorized representative.

Staff Signature:

Individual's Signature: